

IRREPLACEABLE SPECIMEN ATTESTATION FORM

This form cannot be used for Blood Bank specimens.

SECTION 1: To be completed by the health care professional who collected the specimen (Specimen Collector)

NOTE: When a specimen is not positively identified by the health care professional who collected the specimen, results will not be released.

CORRECT PATIENT INFORMATION		INCORRECT PATIENT INFORMATION <i>(if applicable)</i>	
Name:		Name:	
MRN:	DOB:	MRN:	DOB:

CORRECT SPECIMEN INFORMATION			INCORRECT SPECIMEN INFORMATION <i>(if applicable)</i>		
Collection Date:	Time (HH:MM):	AM / PM	Collection Date:	Time (HH:MM):	AM / PM
Accession Number(s):			Accession Number(s):		

SPECIMEN TYPE *(check all that apply)*:

<input type="checkbox"/> Autopsy <input type="checkbox"/> Blood <input type="checkbox"/> Bone marrow <input type="checkbox"/> Cerebrospinal fluid (CSF) <input type="checkbox"/> Culture <i>(specify)</i> : _____ <input type="checkbox"/> Foreign body	<input type="checkbox"/> Outside blocks/slides <input type="checkbox"/> Stone samples <input type="checkbox"/> Tissue <input type="checkbox"/> Urine <input type="checkbox"/> Other specimens <i>(specify)</i> : _____ Body site: _____
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UNLABELED OR MISLABELED SPECIMENS	SPECIMEN ACCEPTABILITY ISSUES (NON-LABELING)
The missing or incorrect information provided with the original specimen was <i>(check all that apply)</i> : <input type="checkbox"/> Patient's name <input type="checkbox"/> Patient's date of birth <input type="checkbox"/> Patient's MRN <input type="checkbox"/> Specimen collection date <input type="checkbox"/> Specimen collection time <input type="checkbox"/> Specimen source (anatomic site) <input type="checkbox"/> Other <i>(describe below)</i>	The reason(s) the specimen failed to meet acceptability criteria <i>(check all that apply)</i> : <input type="checkbox"/> Specimen received beyond acceptable stability <input type="checkbox"/> Specimen received without test orders due to incorrect completion of specimen collection workflow in Epic <input type="checkbox"/> Specimen collected in the incorrect container or tube <input type="checkbox"/> Incorrect media used (formalin, saline, etc.) <input type="checkbox"/> Insufficient sample <input type="checkbox"/> Hemolyzed sample <input type="checkbox"/> Other <i>(describe below)</i>

Additional details describing the improper submission:

Below is a duplicate of the correct label(s) placed over the original specimen label(s) by the health care professional *(if applicable)*:

Affix correct specimen label(s) here *(if applicable)*.

Continue to Section 2

Abbreviations: DOB = date of birth, MRN = medical record number

SECTION 2: Required signatures by Specimen Collector and Ordering Provider

I, _____
 (Print Name and Title)

the person responsible for the collection of the specimen (Specimen Collector), acknowledge that a specimen submission error occurred that has now been corrected (*check all that apply*):

- Unlabeled/mislabeled specimen
- Failed acceptability criteria for testing

I attest to the accuracy of the information in Section 1.

Specimen Collector's Signature: _____ CWID: _____

Date: _____ Time (HH:MM): _____ AM / PM

Phone Number: _____ NYP Lab Witness (*if applicable*): _____

NOTE: The Ordering Provider must be informed of the reason for the request to process the sample by the Specimen Collector, and agree to processing and resulting by signing below:

Ordering Provider attests to the validity of specimen information (above):

I confirm obtaining a new specimen(s) would have a negative impact on the condition of the patient, may yield significantly different diagnostic information and/or is not possible to obtain at this time.

I understand the following statement will be added to the patient's report of laboratory findings as per New York State Department of Health (NYSDOH) and College of American Pathologists (CAP) requirements (NYSDOH Clinical Laboratory Standards REP S2 and SP S4 and CAP GEN.41096): **"The specimen did not meet standard acceptability criteria; however, following review and documented authorization by the ordering physician, it was processed and resulted in accordance with regulatory requirements."**

Ordering Provider (*Print Name*): _____

Ordering Provider's Signature: _____

Date: _____ Time (HH:MM): _____ AM / PM

SECTION 3: To be completed by the Laboratory

Laboratory Personnel Reviewing This Form:

Print Name: _____ CWID: _____

Campus: _____ Laboratory Name/Section: _____

Date reviewed: _____ KEEPSAFE number: _____

Comments: _____

Laboratory Medical Director/Designee Final Review:

Before the test result is reported, laboratory personnel must submit this form to the Laboratory Medical Director or their designee for approval.

Print Name: _____

Signature: _____ Date: _____

This form is filed per local laboratory Standard Operating Procedures and retained in accordance with record retention requirements.